Dermatology Professional Payment Policy

The following payment policy applies to Tufts Health Plan contracted providers who render services in an outpatient or office setting. This policy applies to Commercial1 (including Tufts Health Freedom Plan), Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options (SCO) products.

In addition to the specific information contained here, providers must adhere to the policy information outlined in the professional payment policies for Commercial and Tufts Medicare Preferred HMO/Tufts Health Plan SCO products, located in the Provider Resource Center or on the Payment Policies page.

Note: Audit and disclaimer information is located at the end of this document.

POLICY
Tufts Health Plan covers medically necessary dermatology services.

GENERAL BENEFIT INFORMATION
Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to our secure Provider website or by contacting Provider Services.

Commercial products
Tufts Health Plan does not cover some services that have been determined to be cosmetic, experimental or investigational, as defined in the member’s handbook. Refer to the Noncovered Investigational Services Medical Necessity Guidelines for more information.

Tufts Medicare Preferred HMO and Tufts Health Plan SCO
Tufts Health Plan does not cover elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, procedures or services for cosmetic purposes, anti-aging and mental performance), except when medically necessary.

Note: There is no member responsibility for Tufts Health Plan SCO members.

AUTHORIZATION REQUIREMENTS
For information on reconstructive scar revision for Commercial members, refer to the Scar Revision section within the Reconstructive and Cosmetic Surgery Medical Necessity Guidelines. Refer to the UVB Home Units for Skin Disease Medical Necessity Guidelines for information on a home UVB phototherapy unit for Commercial members.

COMPENSATION/REIMBURSEMENT INFORMATION
Use of noncontracting labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by you as the treating provider or other unreasonable financial exposure. In such circumstances, Tufts Health Plan may hold you accountable for any inappropriate behavior on the part of the non-participating lab that you selected.

Add-on Codes
Tufts Health Plan does not compensate for add-on code(s) if the primary procedure code has not been submitted on the same date of service. Add-on codes pertain to services performed in conjunction with a primary procedure and should never be reported as stand-alone services. If the primary procedure is not allowed, then the add-on code will not be allowed. Refer to the AMA CPT Manual for additional information.

Column I (Comprehensive) and Column II (Component) Codes
The National Correct Coding Initiative (NCCI) has identified comprehensive procedure codes and their associated component codes. Component codes are considered part of the more global comprehensive code and are not eligible for reimbursement when billed with the comprehensive code. Refer to the NCCI Policy Manual for additional information.

1 Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is the primary administrator.
Multiple Surgical Procedures
Commercial
Tufts Health Plan compensates for multiple surgical procedure code(s) by paying the surgical procedure code with the Tufts Health Plan highest allowable compensation at 100 percent. Subsequent surgical procedure code(s) that are subject to reduction logic are compensated at 50 percent of the allowed amount. Refer to the Multiple Surgical Procedures Reduction List for the surgical procedure code(s) that are subject to multiple surgical procedures reduction for Commercial claims.

For information on multiple surgical procedures for Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options claims, refer to CMS.

Wound Repair
If a simple repair procedure code (12001, 12002) or an intermediate repair procedure code (12031, 12032) is billed with a complex repair procedure code (13101, 13121) for the same wound site, then the simple repair procedure code or repair intermediate procedure code will deny as these services are included in the complex repair procedure code. Refer to the AMA CPT Manual for additional information. Tufts Health Plan will consider compensation if the appropriate modifier is appended to the simple repair or intermediate repair procedure code.

ADDITIONAL RESOURCES
Evaluation and Management Professional Payment Policy

DOCUMENT HISTORY
- January 2017: Template updates
- September 2015: Template conversion
- April 2015: Added Tufts Medicare Preferred HMO and Tufts Health Plan SCO; template updates
- December 2014: Moved information about unlisted procedure codes to the Claims Submission payment policy; template updates
- November 2013: Template updates
- September 2013: Template conversion
- April 2012: Template updates
- March 2012: Updated CareLink disclaimer language
- September 2011: Policy reviewed; template updates
- March 2011: Reviewed document for clarity; no content changes made
- September 2009: Newly documented payment policy

AUDIT AND DISCLAIMER INFORMATION
Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, Tufts Health Plan will expect your office/facility to refund all payments related to non-compliance. For more information about Tufts Health Plan's audit policies, refer to our website.

This policy provides information on Tufts Health Plan claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, adherence to plan policies and procedures and claims editing logic.

This policy does not apply to Tufts Health Public Plans or the Private Health Care Systems (PHCS) network (also known as Multiplan). This policy applies to CareLink for providers in the Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna’s provider agreements with respect to CareLink members.